Growing Home SOUTHEAST
Building Families. Building Futures.

Intake Referral Form

Date of Referral: _____

SECTION 1: Client Information ☐ **Self-Referral** ☐ **Other Agency Referral** ☐ **DSS Referral**

Client Name: _____ DOB/Age:_____
Social Security #: _____ Highest Grade/Education Completed:_____
Male ___ Female ____

If Minor: Where Does the child currently reside? Both Parents☐ Mom☐ Dad☐ Other☐
Parent/Guardian Name:_____
Email:_____
Home #: _____ Cell #:_____
Leave Message?: Yes☐ No☐

Physical Address:_____

Presenting Problem(s):
_____
_____

Current ICD-10 Diagnosis(es):
Primary:_____ Secondary: _____ Tertiary:_____ Other:_____

Has the child/family received therapeutic/mental health services before? ☐ YES ☐ NO If yes, please list provider and dates of treatment:_____

SECTION 2: Available Services (Medical Necessity will be determined by Diagnostic Assessment)

☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Crisis Management
☐ Behavior Modification ☐ Family Support Services ☐ Psychosocial Rehab Services
☐ Diagnostic Assessment

SECTION 3: Insurance Information (primary or secondary payer MUST be Medicaid/MCO)

PRIMARY (required):
Type of Insurance: Private pay☐ Medicaid☐ Other☐
Insurance Name:_____
Policy/Member ID: _____Group #:_____
Primary Card Holder's Name:_____
Date of Birth:_____ Social Security Number:_____
Relationship to Primary Card Holder: Self☐ Spouse☐ Child☐ Other☐

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SECONDARY (if applicable):
Type of Insurance: Private pay ☐ Medicaid ☐ Other ☐
Insurance Name:_____
Policy/Member ID: _____Group #:_____
Primary Card Holder's Name:_____
Date of Birth:_____ Social Security Number:_____
Relationship to Primary Card Holder: Self ☐ Spouse ☐ Child ☐ Other ☐

SECTION 4: Referring Agency Information

Referring Agency Name: _____
Referring Case Manager Name: _____
Email: _____
Phone#: _____ Fax#: _____

SECTION 5: To be Completed by Intake Coordinator:

What region does this referral belong to?
If this is a family/self referral; is the family working with any other agency?
When is/are the service(s) expected to start?
Worker preferences (age/sex/race/etc.)?

*Please attach any of the following you may have available:

▢ CCA/DA (assessment) ▢ Psych Eval ▢ CALOCUS ▢ Psychiatric Evaluation ▢ IEP

For Office Use Only↓

First Appointment Date/Time:_____ Therapist Assigned_____
Interviewer's Initials:_____ Welcome Letter sent? Yes ☐ No ☐ When?_____

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